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PROPOLIS AS A REMEDY FOR DIARRHŒAS, ACUTE
AND CHRONIC.

Read before the Kalamazoo Valley Medical Association, October, 1866.

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I take pleasure in bringing to the notice of the members of this Society an article whose medicinal properties have not, as yet, I believe, been laid before the profession. I am confident that, on thorough and honest trial, it will be found to possess virtues that make it worthy a place in our pharmacopœia.

Sometime during the last spring, (1866,) a gentleman made some statements to me in relation to the efficacy of a certain article in diarrhœas, acute and chronic. He claimed for it, also, great efficiency in the treatment of dysentery, and also in cholera.

I promised to give it a fair trial as soon as any cases indicating its use should present themselves. The article then brought to my notice is thus alluded to, and briefly described, in vol. iii of the New American Encyclopedia, under the article "Bee," viz.: "Wax is not the only material used by bees in their architecture; besides this they employ a reddish-brown, odoriferous, glutinous resin, more tenacious and extensible than wax, called *propolis*, which they obtain from the buds of the poplar and birch, and from various resinous trees."

During the past summer I have prescribed it as a medicinal remedy in numerous cases of acute and chronic diarrhœa and

also in several cases of dysentery. I have also presented samples of it to several members of the Society, requesting them to give it a fair trial, and note faithfully its efficacy.

In my own experiments with it, it has proved one of the best and most reliable remedies I have used, in nearly all cases of simple mucous diarrhoea, even when violent, and accompanied by severe pains, vomiting, and collapse. In many cases a single dose has been all that was required. In several cases of diarrhoea in children it has acted like a charm. It appears to possess an anodyne and soporific property, and yet it does not cause constipation of the bowels, but brings them to a normal action at once.

In several cases of dysentery, when given early, it has appeared to have a marked effect in arresting the disease. But in cases where the disease had become established, and especially in those cases where malarious congestion of the mucous membrane characterized the disease, it has appeared nearly worthless.

I have prescribed it in several cases of chronic diarrhoeas, in some of which the disease was contracted in camp. All of these patients have reported to me "that the medicine has acted like a charm," being far more efficacious than any other medicine they have ever used.

The experiments of Drs. Porter, Fisk, and Southard, of this village, have fully corroborated my own. Below I have given several cases.

The propolis is a green resin of a dark-reddish, or yellowish-brown color, of a glistening fracture, slightly conchoidal, of an aromatic taste and smell, entirely insoluble in water, and nearly so in ether, but readily soluble in alcohol and in liquor potassæ. At first I used the tincture, which is of a beautiful wine color.

The following is the formula by which I prepared it for use:

B.—Selected propolis, ----- 3ij.
Alcohol, ----- 3iv.

Dissolve.

Dose for an adult, $\frac{1}{2}$ to 1 teaspoonful in sweetened water; for a child, 5 to 20 or 30 drops, after each stool.

When the alcoholic solution is mixed with water or simple syrup, there is a copious deposit thrown down. The taste is pungently aromatic, but is not unpleasant even to children.

Lately I have used an alkaline solution, as follows:

R.—Propolis, 5ij.
Liq. potassæ, 5i.

Solve *et adde* aq., simpl. syrup, partes $\frac{1}{2}$ $\frac{5}{ij}$.

Dose $\frac{1}{2}$ a teaspoonful after each stool.

The advantage of the alkaline solution is that its admixture with water or simple syrup does not cause a deposit.

CASE I. G. S., a man 72 years of age, called me to see him in the middle of the night, Nov. 14, 1866. He had the day before drank a glass or two from a cask of recently manufactured beer; otherwise he had taken nothing unusual, and appeared at bed time in his usual health. I found him vomiting and purging very frequently—vomiting an ashy looking substance, with dirty, green floccules in it, and the stools were mostly of a thin substance like rice water. There was great pain at the epigastrium and throughout the abdomen, with decided and very troublesome cramps in the legs. Skin was cold and clammy, except about the head; the eyes were sunken; the pulse very feeble, scarcely to be felt at the wrist. I gave him a teaspoonful of a saturated tincture of propolis, and nothing else, except to apply extremely dry heat. He did not vomit again, but had a stool in about 15 minutes. This was followed by another teaspoonful of the medicine. His pain now began to subside, the pulse to be less in frequency, but fuller and stronger. In about an hour he had another stool, which I followed by a dose of $\frac{1}{2}$ a teaspoonful of the remedy. He required no more, and became speedily convalescent.

CASE II. I was consulted about this time by a young man for a friend of his, who had gradually increasing on him for some months a chronic diarrhoea, accompanied by pain and soreness throughout the abdomen. I gave him the alkaline solution above indicated, in doses of $\frac{1}{2}$ a teaspoonful three times a day. Three days after, the pain and soreness had all passed away, and the stools were nearly or quite normal in frequency and consistence.

CASE III. (By Dr. Porter.) H. P., during a typho-malarious fever, was attacked with diarrhoea. Dejections every 20 or 30 minutes; very dark and watery, and accompanied by vomiting. Ordered a teaspoonful of a mixture of equal parts of tinct. propolis, and simple syrup, to be repeated every two or three hours. The first two doses were rejected. After the third, vomiting ceased, and no stools for two hours, and another dose ended the diarrhoea entirely.

CASE IV. (By Dr. Fish.) October 31, 1866, was called to see Mrs. P., who had had chronic diarrhoea for two years, not having had a natural stool within that period; stools generally were from two to four per day. There was attending the diarrhoea a great deal of soreness over the liver, stomach, and bowels. In one week the tincture of propolis, in doses of $\frac{1}{2}$ a teaspoonful three times a day, had entirely cured her.

I take pleasure in submitting the above to the profession, and in submitting the article to, and asking for it, the careful and honest test of its experience.

**ON THE IMPROVED METHOD OF TREATMENT OF
DISEASES OF THE LUNGS, THROAT, AND NASAL
PASSAGES, BY INHALATIONS OF ATOMIZED
FLUIDS.**

BY WM. C. LYMAN, M.D., late Surgeon U. S. Navy, Resident Physician U. S. Marine Hospital, etc.

The use of atomized liquids has within the past year occupied a prominent place in therapeutics, as applied to diseases affecting the respiratory passages. The great number of cases of that class that occur in the higher latitudes, and their importance, as bearing upon the health, and often the life of the individual, render their correct treatment, and the use of every proper remedial measure, one of the most sacred duties of the physician. Although the use of atomized liquids has its opponents, as being an ineffectual measure, the profession not only has adopted it, but has found it a valuable adjunct to

other means before practiced. It is to contribute to the sum of evidence upon this subject that I have been induced to make a series of observations, which form a part of this communication.

It is a fact, patent to every one, that the function of respiration plays a very important part in the human economy, and that poisonous gases and other substances are readily received into the body, and rapidly produce their characteristic, or specific, effects when introduced. It may be safely concluded that attempts to gain a beneficial influence through this function would not be abortive, for similar reasons.

It is also true that local medicaments have as important a place in therapeutics as those which are introduced into the system; in fact, there are many diseases that are now treated wholly by local applications that were formerly thought only to yield to mysterious combinations of drugs, which, by some power, neither known nor explained, accomplished the desired work: thus fostering that benighted condition that leads the Indian to implicitly believe his "medicine man," when, after some infernal incantation, he tells him some specious untruth, or that which is only another phase of the same love of the mysterious, or belief in that only which cannot be understood, by investing a simple drop of water, or grain of sugar, with a power that mocks the infinite.

Inhalations of atomized or pulverized fluids may be made available for the application of both local and general remedies, producing first their local effect, and, by absorption into the circulation, their habitual impressions. It is always well to produce as direct an impression as possible, thus requiring a less dose, and a less prolonged impression, as, for instance, the hyperdermic use of morphia, compared with its introduction by way of the stomach.

Inhalation as a remedy is no new thing, as every one knows who is at all familiar with the literature of the profession; but until the pulverization of fluids was accomplished and put in practical use, we were not one step in advance of the physicians of ancient Greece in this particular thing of inhalations. But

now we claim a step forward, that this is a valuable addition to therapeutics, as necessary as any other.

The various instruments and their parts have been so often and fully described in medical publications that I will only say that those made by Gemrig, of Philadelphia, and Codman & Shurtleff, of Boston, answer every purpose that can possibly be required of a steam instrument of this kind, and the one of Andrew Clark, which consists of two globes, to maintain a steady current of air, will, equally well, accomplish the object for which it is designed. A third instrument is that of Oliver's, which has the tube fitted to a glass receiver, containing the atomizing tube, and which has an opening for the mouth to receive the spray.

The method of administering these inhalations deserves, at least, a passing notice, for it is sometimes difficult to prove that the spray passes into the respiratory passages at all, but is claimed that it finds a lodgment upon the pharynx and glottis, the respiration air then being deprived of its particles of fluid. But we find irrefragable proof that atoms of liquid thus produced, do penetrate into the minor branches, in the interesting experiments detailed before the Academy of Medicine in Paris, by M. Demarquay. One of these is thus described: "Several small animals, as rabbits, cats, and Guinea pigs, were forced to inspire an atomized solution of one of the per-salts of iron, for a period of nearly ten minutes, the nostrils being closed. The presence of iron, even in the pulmonary tissue itself, was plainly demonstrable by the proper tests, the prussiate of potash, and acetic acid. Also, a patient in the hospital, who had an opening in the trachea submitted to an experiment being made upon himself in the following manner: A probe, covered with paper moistened with tr. chlor. ferri, was introduced into the trachea, and a strong solution of tannic acid was inhaled for a period of three minutes, a decided black, inky color was obtained." It is a well established fact that coal miners, often present evidence of finely divided substances having found their way into the air vesicles themselves. We have often noticed in using either very warm or very cold vapors, that the

sensation of warmth or of cold was experienced throughout the entire extent of both lungs.

While it must be acknowledged that atomized fluids find their way into the more minute bronchi and air vesicles themselves, it is impossible to say how great a part of every ounce of liquid thus used pervades, in this manner, the whole bronchial tract, and we can only approximate it by judging from the effect produced upon the individual. A œdema about the glottis, or swelling of the vocal cords, are obstacles of a mechanical nature, to the free ingress of vapor, and in any case of failure to obtain the desired effect, such obstacle should be sought for, and, if possible, removed. It is difficult to breathe the atomized fluid through the circuitous nasal passages, without raising the head, and taking care that the tongue is well depressed, and the body inclined so as to make the most favorable angles within the passage traversed by the vapor. The impinging of the current upon any salient point causes a precipitation that soon deprives the air of nearly every perceptible particle of vapor, and it passes into the lungs in its un-medicated condition. I have several times tested this matter, watching the inhalations closely, and examining the patient with the laryngoscope subsequently, using liquids of unmistakable color, and find that none had penetrated further than the fauces. Afterwards, when the patient had carefully adjusted his position, the color extended beyond the reach of the laryngoscope, and expectoration was tinged with the color used in the experiment, for some time after.

The application of remedies is the most important part of this subject that occupied our attention after demonstrating the possibility of their use in this manner. The observations of the writer extend over a series of about seventy cases of disease of the respiratory mucous membrane. It is impossible to give more than an outline of the treatment of these cases in an article of this length, embodying the general considerations only. About one-fourth of these cases were catarrhal inflammation of the nasal passages, in several cases extending to the pharynx. There was a profuse discharge from the nostrils—

sometimes of offensive character, occasionally streaked with blood, with pains about the frontal sinus, and an apparently thickened or swollen condition of the pituitary membrane. This condition had gradually come on through several months. There was a partial loss of smell, and the voice was considerably changed; there was found to be gradual and steady improvement under the use of a solution of chlorate of potash, alternated sometimes with sulphate of iron and tr. sanguinaria. The inhalations were rarely given more than twice daily. The chlorate of potash appears to be applicable to acute and sub-acute conditions, controlling inflammation and relieving discomfort in a remarkable degree. Acute conditions frequently require anodyne applications along with the chlorate, such as hyoscyamia, aqueous ext. of opium, or conium, to get the best result.

Some ten or twelve cases of pharyngitis, not all identical in character, came under observation—some of which were type cases of “clergyman’s sore throat.” These yielded readily to a solution of nitrate of silver, at first, and, subsequently, a strong solution of tannin. At the end of a week a marked change for the better was apparent. In one case, particularly, where the whole lining of the throat was intensely red and inflamed, wherever it could be brought into view by depressing the tongue, and by the use of the laryngoscope, from the palate to the glottis. The pulverized solution of nitrate of silver was used twice only before a great amelioration took place in all symptoms, checking the inflammation almost immediately. The spray is much preferable to sponging, as a more agreeable operation to the patient, and applies the agent to all parts—a difficult thing to do with a sponge, which only touches the most exposed portions, leaving those deeper more difficult, and often more inflamed parts, untouched by the remedy.

In syphilitic inflammations of the throat, great benefit followed the use of dilute preparations of creasote, corrosive sub-limate, iodine, and permanganate of potash, but it is wholly improbable that these alone would have effected a cure, constitutional remedies being, of course, a *sine qua non*. Eleven

cases of secondary syphilitic disease thus came under observation.

The remainder of the cases, included among those who came under particular observation, were of chronic bronchitis, some having tubercular deposit in the lungs, as determined by physical exploration of the chest, together with a profuse expectoration and cough. Some of the more advanced were only benefited as far as temporary relief of the cough and profuse expectoration. Others, less far advanced, decidedly improved, and gained flesh and strength, using cod liver oil, and other kindred remedies, also. Solutions of sulphate of copper, tannin, alum, acetate of lead, nitrate of silver, and Lugol's solution of iodine, with and without opium, were used in these cases. The preference is given to sulphate of copper, tannin, and nitrate of silver. I have only one case of haemoptysis that was sufficiently well marked to be of importance. It occurred without much pain or febrile movement, in this instance; used the solution of per-sulphate of iron, much vaunted for its styptic properties; a very weak solution was inhaled with great good effect in promptly checking the hemorrhage. Opportunity occurred for the use of the atomizer, in a single case only, of whooping cough, occurring in a child of four years. Inhalations of dilute solution of belladonna, with occasional alternations, with solution of alum and conium, apparently greatly modified the severity of the paroxysms, they being less frequent and distressing, and of less duration, with easier expectoration.

A medical gentleman of this city informs me that he has used inhalations of lime water in two cases of inflammatory croup, in one of which preparation was being made for tracheotomy; recovery followed in both cases. The use of aqueous vapor is no new thing, it is true, but the prompt action leads to the opinion that the solvent power that the lime water exerted upon the inflammatory exudation within the trachea determined the favorable result.

The same remedy has become a popular one for the diphtheritic exudations about the throat, and in the nostrils, and deservedly so, judging from the evidence upon this point contained

in the late contributions to medical literature upon this subject. It is certainly the most available method of using any topical remedy.

When, on account of the tenderness and swelling, the application of the sponge is wholly impossible, and the use of a syringe wholly inadequate, we may consider it a very valuable addition to the remedial measures for these affections. The following cases, given in detail, will probably sufficiently illustrate the beneficial effects of this plan of treatment.

CASE I. J. W., native of the United States; had served three years in the army of the South-west, during which period he contracted a troublesome cough, which had existed for eighteen months, when he came under observation. He had been under treatment for months, going from one place and physician to another, but had probably been impatient, and failed to fully carry out any plan. He said he had a "*bushel of empty bottles at home*," showing that he had not been wanting in medicine, at least. He was emaciated, expectorating copiously; respiration at least 28 per minute; pulse about 90. He had little appetite; walked up a flight of stairs with great difficulty; coughed very much on lying down; complained of great pain in his chest, at times, and always when coughing. The alvine and urinary evacuations were normal in character. The most minute and repeated examinations failed to discover any tubercular deposit in the lungs, although expected; he had never had haemoptysis. Failing to discover tuberculosis, it was concluded that there was only a general sub-acute bronchitis. He inhaled twice daily a solution of chlorate potass, with tr. opium, sometimes alternated with acetate of lead and morphia; tr. sanguinaria was used at times, with each of the above preparations. He was given an expectorant mixture, of very common place character, more as a placebo, than anything else. He steadily improved from about the second day, when the beneficial effect of the remedy became obvious. The second night after beginning the inhalations was the first quiet night he had had for weeks; he expressed himself as very much relieved, and very grateful

withal. His appetite gradually returned; he gained weight; his respiration returned to a natural frequency. At the end of two weeks he could take five times the exercise that was possible at first; he coughed and expectorated comparatively little. When first used the vapor produced a suffocative feeling, with an almost incessant, short, hacking cough, which passed away in half an hour. As he became more accustomed to them, the inhalations were a source of comfort, producing no cough or dyspnoea. These were continued for about a month; the patient steadily improving, when he went to work, with only a trace of his cough left.

CASE II. E. B., merchant, age about 45; has had catarrhal inflammation of the nasal passages for the past five years. It was originally a "cold," that, neglected and aggravated by exposure, has continued on till he finds himself in a condition that he describes himself, in nearly the following words: After recovering from the first symptoms of the cold I felt well, and thought I was well, but a slight discharge from the nostrils ensued, and slight soreness, which has always remained, growing worse and worse, with each slight exposure, till now I have constantly a good deal of discharge, often streaked with blood, and purulent in character, and of disagreeable odor. I cannot go to church, or to any place of amusement without being conscious that a disagreeable coughing, hawking, and expectoration may be unpleasant to those near me. The perception of odors is much less acute than formerly; am depressed; have lost between fifteen and twenty pounds in weight, and am really discouraged, having tried a great many medicines, and feel no permanent benefit from their use. This is, perhaps, a type of many cases that are seen of inflammation of the nasal mucous membrane. The truth is that they are benefited in the same way by local treatment, that inflammation of the conjunctiva, and other mucous surfaces are. Injections with a syringe, and the use of powders, never more than partially accomplishes the desired object, reaching only a small part of the affected surfaces; whereas, the use of pulverized liquids enables us to apply the medicament to the whole. In this case the

treatment was mainly the inhalation, twice daily, of an atomized solution of nitrate of silver, great care being used to prevent the discolorization of the face, by protecting the adjacent parts by covering with oil, and enveloping the face in a towel during the process of inhalation. After the first eight or ten days a solution of chlorate of potash was substituted, which was continued, with occasional alternations, with the nitrate, for several weeks. The progress toward recovery was regularly progressive; the mucous discharge becoming less in quantity; the offensive odor being controlled; the sense of smell re-established, and the patient improving in general condition. Chalybeates were prescribed in connection with the local means; but it is wholly improbable that they would have produced this effect alone. This patient was under observation for over two months.

CASE III. R. G., native of Germany; age 42; has been a sailor for twenty years; has always been in robust health, notwithstanding the exposure incident to a sailor's life, till eight months ago, when he contracted a pneumonia, which left him with a cough, and greatly debilitated; he continued in this condition for weeks, notwithstanding a tonic course of treatment being pursued. The frothy and copious expectoration continued; slight dullness was observed under the right clavicle on percussion, and large, dry crepitus was developed, with prolonged expiration and bronchial voice. These, with the general indications, showed conclusively the presence of commencing tubercular infiltration. At this time a slight, passive haemoptysis occurred, an ounce or so of nearly pure blood being expectorated. Several successive attacks followed, a few days apart, with the sputa usually streaked with blood during the interim. Inhalations of styptic character were used at this period, (Monsil's salt,) once daily, which arrested the haemorrhage at once, and appeared to prevent its recurrence as before, the patient acquiring a great degree of relief from his cough and expectoration, and improving in general condition. How far the curative power of this measure extends as a remedy in tuberculosis, may possibly be determined by subsequent obser-

vations, at present, we know it is a valuable and convenient means of controlling an alarming symptom, which alone would entitle it to a favorable consideration.

The doses in which these preparations are to be used, constitute a point of practical importance, to meet which will be appended the following tabular statement. This statement is for adults, and is to be diminished for children, according to the usual rules, proportioning the dose for the age. Several tables of like character have been made public, and in general features they all necessarily correspond; but it is my desire to present the conclusions that whatever opportunity of observation and experience I have had, has enabled me to arrive at this calculation, shows the proper quantity to the oz. of water:

1. Tinet. ferri susqui chloridi,-----10 to 20 m.
2. Liq. ferri per-sulphatis,-----5 to 15 m.
3. Alum, -----10 to 20 grs.
4. Tannin,-----5 to 30 grs.
5. Sulph. zinc,-----2 to 5 grs.
6. Sulph. cupri,-----1 to 4 grs.
7. Argenti nitras,-----1 to 10 grs.
8. Potass. chloras,-----10 to 30 grs.
9. Lime water,-----Officinal strength.
10. Opium ext.,----- $\frac{1}{2}$ to 1 gr.
11. Morphia,----- $\frac{1}{8}$ to $\frac{1}{4}$ gr.
12. Liq. iodini comp.,-----2 to 4 m.

NASAL POLYPUS.

By R. P. HUNT, M.D., of Chicago.

DEAR DOCTOR:—

When the late civil war, or rebellion, closed, I was on duty in hospital, at Columbus, Ga. The surrender having taken place, I, like all others, concluded to reach my own loved ones, whom for years I had not seen. Accordingly, I left Columbus, where I was stationed, and wended my way towards Louisville, where my family was. In returning, it was necessary to repass ground once before passed.

On reaching Griffin, Ga., where I had been previously stationed, I found surgeons of long-standing in the rebel army, like myself, thrown out. It was necessary to remain there, but whilst there, a singular case occurred:—

I was called in consultation by one of the Confederate surgeons, upon a case of most peculiar character. What was it? **A case of nasal polypus.**

Some months previously the soldier presented himself at the hospital for treatment; it was then found impossible to remove the polypus as it is ordinarily done. The nose was necessarily split on the side requiring operation, and the excrescence removed. The tumor returned.

A few months after, when there was no Dixie, and I was wending my weary way towards my family and home, if I had a home, I was compelled to stop a few days at Griffin, where I previously had been on duty. Whilst there, a fellow-surgeon called my attention to this case.

The war was over, and all hospital accommodation broken up; yet it did not enter the mind of a medical gentleman to see suffering and not attempt to relieve it. Being there, the medical officer who had previously treated the case requested me to examine it. Thus it was simply a case of charity, and not of army surgery.

After a close and minute examination, I found out that the patient could not sleep in a recumbent position. He was compelled, by the pressure upon his epiglottis, to remain in a chair, as are many cases of asthma. A slight doze, and he would fall and bruise himself. Sleep was really no rest to him; he was young and otherwise vigorous. The case was urgent. Having no means of treating him, we advised that he should pass on to Nashville, enter the hospital, and be well and properly treated. No! he had no money, and could not walk that distance. Like him, we had no money; so what was to be done? The question was ultimately referred to me for a final decision. And now for the case, as I think I have wasted enough of my time and your pages.

The boy came in; I examined him, and saw from the effects

of the previous operation that it had been totally ineffectual. My opinion was asked. It is needless to say, the war being over, there being no hospital accommodations, no means of caring for the sick, I agreed with those who wished to send him to a Nashville hospital for treatment. To this he objected strenuously, giving as reasons his utter disbelief in the possibility of reaching there, that he could not lie down and sleep, that he was suffocating, and that unless relieved he would prefer death immediately. Called upon for my opinion, I first agreed with those preceding me, it was best, if possible, to reach a hospital. To this advice he would not listen. Then, what to do?

The left nasal passage was entirely filled, neither forceps nor probe could pass. The polypus was hard and unyielding; the patient was almost suffocating. He claimed relief, and claimed it as a right. There was but one means to resort to; the previous operation had been fruitless in its results, a new one was necessary. What was it to be?

On an examination, as careful as I could make, I suggested the possibility of the polypus having forced its way into the highmorianum antrum. Thence, the operation to be performed: first, slit up the nose, remove the nasal portion of the polypus, and verify or falsify the diagnosis; if correct, the superior maxillary must be removed. Well, the patient was informed of all his chances, and still advised to proceed to Nashville and enter a hospital. No! "I will die before reaching there, and prefer to die in making an effort to live; cut on." Finding this courage, this indomitable will, the operation was performed. The whole of the left nares was occupied by a substance fully as large as the egg of a pullet, as a matter of course a pullet's egg somewhat elongated; it was thoroughly impacted, reaching from the external orifice back to the pharynx; it also, as had been foreseen, branched off into the antrum. On removing the superior maxillary, the cavity was found filled to its utmost capacity. The excrescence was of a scirrhus character, evidently malignant. The result was what he wished—death.

Prof. Gross says, "there are only two" special forms, "the

gelatinous and fibrous." "The *fibrous polypus* occurs at nearly every period of life. * * * * For the removal of the *naso-pharyngeal* polypus two distinct operations have been proposed: one by Nélaton, * * * the other by Flambert, of Lyons, consisting in the excision of the upper jaw, first practiced by him in 1840, and now recognized as a perfectly legitimate procedure."

This information was not before us at the time the case in question plead for relief.

Proceedings of Societies,

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SHELL WOUND OF THE HEAD.

Dr. Dunn reported an exceedingly interesting case of injury to the skull, produced by a fragment of shell.

The patient, a surgeon, while on duty during battle received the injury over the inner circle of the left eye. It was quite extensive, implicating not only the soft tissues, but also the bone beneath. There was complete insensibility for several hours. In due time the wound healed, with the exception of a small fistulous opening, leading to carious bone.

The patient was subject for two years to frequent paroxysms of terrible neuralgic pain in the head, numbness of the integument, with a sense of stricture around the forehead. There was at times a slight discharge of purulent matter from the nostrils.

Although the patient has suffered much, and has at times been incapacitated for mental or physical labor, he has yet devoted himself to his professional duties.

Some weeks ago a few small fragments of bone escaped through the nostril, since which time the painful symptoms have entirely subsided.

CANCEROUS DISEASE OF THE OESOPHAGUS, WITH ULCERATION INTO THE BRONCHI.

Dr. Fisher exhibited an instructive specimen of cancerous disease of the oesophagus, implicating both lungs.

The patient, aged 52 years, had suffered some time from irritation of the stomach, and difficulty in retaining his food, when, in July, 1866, he sought the advice of Dr. F.

The patient was emaciated, apparently from want of food; for, although his appetite was good, he was unable to swallow. After the passage of a small probang through the obstruction, he was able to swallow liquid, with considerable difficulty, however, for three weeks. Subsequently it was necessary to pass the probang every few days.

During the last five weeks of the patient's life there was increasing difficulty of breathing. There was marked dullness, with crepitant rales; food which he attempted to swallow was coughed up. Patient died early in May, 1867.

An examination revealed the presence of ten ounces of serous fluid in the right thoracic cavity. The oesophagus was attached to both lungs. There was quite a large opening through its walls into the right bronchus, the contiguous portion of the lung being gangrenous. On the left side there was simply a small communication into the bronchus, with scarcely any disease of the substance of the lung.

The lower portion of the oesophagus, throughout its whole circumference, and to an extent of about four inches in length, was indurated, its sides perforated, and its internal diameter contracted to the size of a quill. The microscope showed the structure of the growth to be malignant.

ENCEPHALOID MASS PENETRATING THE RIGHT RENAL VEIN AND THE VENA CAVA.

Dr. Bogu exhibited a very remarkable specimen of cancerous growth, which he had removed from a patient in the Cook County Hospital.

The patient, aged 35 years, male, entered the hospital in May, having suffered about two months from pain in the left side of the abdomen and chest, haemoptysis, coldness of the ex-

tremities, night sweats, and loss of appetite. The erect posture produced dizziness and blindness; the horizontal posture produced tinnitus. There was crepitation in each lung, nausea, constipation, and little urine; the right leg was paralyzed, enormously oedematous, as far as the middle of the thigh, and covered with a large number of black patches. There were many dark colored nodules, varying in size from that of a pea to that of a pigeon's egg, on the scalp, back, and along the course of the lymphatics. There was also an abdominal tumor above the umbilicus, which had escaped the notice of the patient. At last there was pain in the bladder, with retention of the urine, and oedema of the left foot. Death occurred a few days after the patient's entrance into the hospital.

The autopsy revealed a large encephaloid mass, situated over the lumbar vertebra, which were found diseased into the very cavity of the spinal canal. The mass involved the vena cava and right renal vein, penetrating their walls, and nearly filling their cavities with a soft fungus mass. There were deposits of cancerous structure in the lungs, liver, and abdominal glands.

OURVATURE OF THE SPINE.

Dr. Earle reported three cases of curvature of the spine in children, which had been successfully treated by means of a modification of Dr. Taylor's apparatus, which the reporter exhibited and explained to the Society.

Dr. Danforth exhibited a singular, hard, chalky concretion, elipsoidal in shape, one and a half inches by an inch in diameter, which he had removed from under the chin of a female patient, 28 years of age. The tumor had existed twelve years.

SUCCESSFUL REMOVAL OF AN OVARIAN TUMOR.

Dr. Seely read a report of a case of ovarian tumor, which had been successfully removed by Dr. Burnham.

The patient, 31 years of age, had married at the age of 20, and borne four children. In September, 1864, she suffered from the presence of an abdominal tumor. As it developed it became necessary to perform the operation of paracentesis repeatedly, to relieve the great tension, nausea, vomiting, and

vaginal prolapsus, caused by the excessive ascites. For a year or more she was in this way rendered quite comfortable. During the last five months, however, the operation had been performed sixteen times, removing at each time fourteen quarts of serous fluid. The tumor was removed on the 30th of May last. An incision of the usual length having been made through the walls of the abdomen, the tumor was carefully withdrawn, the peduncle ligated, and then divided with the knife. The wound in the abdomen was closed by means of silver sutures, support being given by means of a bandage around the body. After the operation there was scarcely any prostration. Patient slept well; pulse continued a few days somewhat more frequent than normal. There was also considerable intestinal pain, which was readily relieved. The recovery was perfect, in four weeks.

TUMOR OF THE CHOROID.

Dr. Holmes exhibited an eye of a patient at the Chicago Charitable Eye and Ear Infirmary, 52 years of age, who had suffered two years most violent pain in and around the orbit. The globe was soft to the touch, the pupil occluded, iris discolored, conjunctiva congested, but not œdematosus; vision had long been totally extinct. The diagnosis was doubtful. As all efforts had failed to relieve the pain, it was deemed best to extirpate the globe. Within it was found a well defined, hard, very dark colored tumor, three-eighths of an inch in diameter, almost spherical in form, attached to the choroid, at its outer and posterior portion, near the optic nerve. It was composed of a fine granular mass, with pigment cells.

PEORIA COUNTY MEDICAL SOCIETY.

Pursuant to call, the following medical gentlemen assembled at the office of Dr. H. Steele, in Elmwood, Peoria County, Ill., June 15th, at 1 o'clock P.M., for the purpose of organizing a Medical Society:

Dr. G. L. Corcoran, Brimfield; Dr. F. A. Warner, Farmington; Dr. John Gillette, Tivoli; Drs. Hensley and Hoit, Yates City; Dr. J. K. Secord, Elmwood; Dr. H. Steele, Elmwood.

On motion, Dr. Corcoran was chosen temporary Chairman, and Dr. Steele, Secretary.

After the adoption of a Constitution and By-Laws, the Society proceeded to the election of permanent officers for the ensuing year, which resulted in the selection of the following gentlemen:

President—G. L. Corcoran.

Vice President—John Gillette.

Secretary—F. A. Warner.

Treasurer—H. Steel.

Censors—W. Husley, Hoit, and J. K. Secord.

Communications were received from several medical gentlemen, who had been unable to be present, to the effect that they would endorse the proceedings of the Society.

The Society then proceeded to the adoption of a fee bill.

The following subjects were selected for discussion at the next regular meeting:

Administration of Medicine by the Hypodermic Method.

Bromide Potassium.

Cerebro-Spinal Meningitis.

After a brief discussion upon various medical topics, it was ordered that a synopsis of the proceedings be furnished the Chicago MEDICAL JOURNAL and Yates City *Herald*, for publication.

On motion, the Society adjourned, to meet at Brimfield, on Wednesday, Sept. 4th, 1867, at 1 o'clock P.M.

G. L. CORCORAN, Chairman.

H. STEELE, Secretary.

Foreign Correspondence.

HEIDELBERG, July 14th, 1867.

DEAR DOCTOR:—For the present I find myself domiciled in this ancient and beautiful city of the valley of the Neckar. There is just room enough for the city between the river and mountain, which rises abruptly to the height of 1800 feet. On the opposite right bank is another range of similar height, springing

from the very water's edge. At the lower limits of the city this narrow valley opens out on a plain, extending beyond the range of vision. This plain is under the highest state of cultivation, and owing to the tortuous course of the river is very accessible to its benefits. This assemblage of mountains, valley, and river, can be seen in "bird's-eye views" from any of the neighboring peaks, and is altogether the most charming natural *picture* that it has ever been my good fortune to witness elsewhere. Heidelberg has a population of 16,000 *humans*, and because of its being a popular resort for pleasure and sight-seeing, one finds almost every nation and tongue represented, particularly in public places. Its claims to antiquity crop out here and there in the architecture of olden times, represented by a few buildings that were spared by the incendiaries under Gen. Medoc, who led the French against it in 1693—Louis XIV. time. Among these reminiscences that were spared was a portion of the feudal castle, situated on the mountain side just above the city. It contains many curious relics of the past, such as old pictures, mostly representing Saints, or "God's anointed" tyrants, implements of warfare, and last, though not least, the famous old wine cask, 30 feet long and 28 feet in diameter, and capable of containing 300,000 bottles of wine. I did not take much interest in that "barrel," because it is quite empty now, and the bung hole does not even smell of the ghosts of good drinks that it once afforded.

The University, founded A.D. 1386, under the Elector Rupert III., is one of the most celebrated in Europe, consequently is the resort of students from all parts of the world. The usual number in attendance is about 800. They are for the most part jolly, rollicking looking fellows. I learned that their principal recreation is fighting duels with swords, and, owing to this, one may pick them out on the streets by the variegated scars on their faces. The above remark is only true of the seniors, the juniors (or "fuchses or foxes") have to bide their time for this badge of honor. One would look upon this custom as rather risky, until informed that every part of the body is protected by a coat of mail, excepting the cheeks. The eyes are covered by a pair of huge iron spectacles. A Sioux Indian is not prouder of a white man's scalp than one of these young rascals of his numerous cheek gashes—the fresher the better.

From force of habit, or because I understand it best, the medical department has most charms for me, in which I had the extreme pleasure of meeting my former pupil and friend, Dr. Samuel Cole, of Chicago, for whose kind attentions and valuable aid I am much indebted. Although young, the Doctor is already quite ripe in medical and surgical lore, having graduated at Rush Medical College, attended one year at Bellevue, one year in Paris, and already six months in this city. He informed me that he considers this institution much to be preferred to any other that he has visited, mainly because of the thorough method pursued in giving clinical instruction, which method, as I have learned by observation, is about as follows, viz.: The Clinical Professor selects in rotation each morning a different member of his class, who is directed to make the clinical examinations, embracing diagnosis, pathology, prognosis, etc., the teacher correcting all mistakes at the time. Of course this plan can only be pursued with a limited number of students, but, circumstances per-

mitting, it is certainly very practical. The young men who enjoy these privileges are advanced students or graduates. Could not a similar plan be adopted in Rush Medical College for advanced students and young graduates, as an institution independent of the regular course of instruction, and made an appendage of the Dispensary? I send you a synopsis of a clinical lecture by the celebrated Prof. Friedrich, (Lec. on Theory and Practice,) as an example of the painstaking plan of examining cases for the instruction of student, and this is true of all the departments. In the above case, Prof. F. caused his selected pupil to repeat the anatomy of the entire nervous system at the base of the brain in arriving at an accurate diagnosis. Prof. Knapp, in his Eye Clinic, pursues the same severe analytical course, causing the pupil whose "turn it is," to hobble on before him, always holding himself in readiness to correct mistakes or to elucidate obscure points.

Owing to the poverty of the masses in this country there is always an abundance of clinical material, consequently their large hospital is always well filled with every variety of disease. I am aware that "comparisons are odious," but must, nevertheless, indulge somewhat respecting our surgery and theirs. For example, in the treatment of hip-joint disease, they make use of an immovable apparatus, consisting of a plaster of Paris case, which embraces both hips and the affected thigh, provided with convenient openings for the escape of excreta and pus, in imitation of "Bauer's wire breeches." It is true this partially fulfills the indications of "mechanical and physiological rest," but the most important indication is unfulfilled, which is the separation of the joint surfaces by extension and counter extension, thereby counteracting the mischievous effects of the ever contracting muscles, at the same time (as in the use of Taylor's or Davis' elegant splints,) rendering it expedient for the patient to go about and receive the benefits of open air, moreover, offering the additional advantage of avoiding subsequent ankylosis. I had occasion to observe the same plan of treatment in caries of the knee and elbow, which must necessarily result in true ankylosis, if the cases happen to terminate so fortunately, in these merciless vices of plaster. The fact is, these Europeans could learn something regarding mechanical surgical treatment by coming to the United States, for in this department we are far in advance of them, while I am ready to acknowledge that in most purely scientific departments we must concede an inferiority, not that our endowments for scientific research are inferior, but time is too valuable with us to spend it in the comparative anatomy of the "germinal spot" of the egg of an itch-mite.

Their plastic operations excel in neatness of execution and success anything I have seen elsewhere, and one may add that their surgical operations generally exhibit a great deal of skill. Weber, the surgeon, and a man of much eminence, died a few days since of diphtheria. His handiwork still adorns the hospital, in the form of plastic operations, resections, etc. Prof. Heine—a man of less celebrity, but perhaps of equal skill, fills his place until the regular appointment is made.

Heidelberg is the home of the celebrated surgeon, Chelius, (the author of Chelius' Surgery,) to whom I had the pleasure of an introduction. He is quite

aged, being upwards of 80 years, and has retired from the profession, although still possessed of an active mind. He spoke very feelingly of Mott, for whom he seems to have entertained much respect. When I mentioned Brainard's death, he quickly signified that he was aware of it, and commenced conversing about his improvement in the treatment of ununited fractures, for which he gives him much credit.

Dear Doctor, I do not think I will be home before the last of October, as I have so much laid out to accomplish that it will consume all that time and more. I have not heard a word about the College since leaving home, but expect a letter from you hourly, in which I expect to find all the news I desire. Neither have I received the MEDICAL JOURNAL that you promised. Please send it along. I expect to go to Tübingen in a few days, in order to visit their medical school, when you will hear from me again, if I can gather anything of interest.

Respecting ourselves, we are all enjoying excellent health, and enjoy the city of our temporary adoption. My letter, you will notice, was commenced at Heidelberg, but it has been completed at home. I do not think there is anything in it worth publication, unless it may be a little account of the medical school, and you must be the judge of that.

Please present my kind regards to the Faculty.

Sincerely, your friend,

J. W. FREER.

Prof. J. ADAMS ALLEN, Chicago.

P.S.—Our address is now 52 Neckar street, Stuttgart, Wurtemberg, Germany.

J. W. F.

HEIDELBERG, Germany, July 18th, 1867.

TO THE EDITOR OF THE CHICAGO MEDICAL JOURNAL:—

Dear Sir:—A graduate of Rush Medical College will always look back with pride and pleasure to the good old days passed in the pursuit of science, in the halls of his beloved *alma mater*. With such feelings, I now offer to you, for publication in your admirable journal, the report of a case which has been of considerable interest to me, hoping that, at least, it will not be unacceptable to your readers:—

N. B., *aet.* 63, entered the hospital June 24, 1867. He dates his disease back fifteen years. He had been a laboring man. Fifteen years ago, he commenced to feel occasional drawing pains, periodical in their return. From this time he began to lose flesh, and now is so emaciated as to present the appearance of a real living skeleton. He entered the hospital on account of swelling of the lower extremities and difficulty of swallowing.

About three weeks ago, he began to feel great difficulty in breathing and coughed, expectorating mucus. At about the same time, he vomited about $1\frac{1}{2}$ pints of blood, followed by bile. The appetite is good and the digestion perfect, at present. This sudden haematemesis was probably due to ulcer of the stomach, and has but little bearing on the case. The oedema of the lower extremities appears to be owing to passive venous congestion, the veins having lost the support of the muscles, and thus, one of the most important conditions of a perfect venous circulation, namely, the contraction of the muscles, being removed. That it was due to a passive venous congestion is demonstrated by the fact of its disappearance after the patient had retained the recumbent posture for a few days.

The difficulty of breathing is caused by atrophy of the intercostals, the lungs being in a healthy condition. Heart normal; bowels constipated; urine normal. The dysphagia is extreme, the patient being totally unable to swallow solid food. The morsel remains in the oesophagus, or, rather, in the pharynx, excites a paroxysm of coughing, and is again regurgitated. Liquids still pass, but with difficulty. This dysphagia is ascribed to atrophy of the constrictors of the pharynx and oesophagus. On first inspecting the patient, one is struck with the emaciated appearance he presents. The muscles are *all* atrophied and *some* have disappeared. The arm and thigh are comparatively unaffected; the strength, in a measure, being preserved. I say comparatively, for they are not of the size and strength of those of an adult. The hands and feet, legs and forearm are greatly emaciated, and *here* the extensor muscles have suffered most. The balls of the thumbs have entirely disappeared, and no trace is to be found of the lumbrales and interossei. The fingers are bent so as to resemble claws, and the patient is unable to straighten them, or to retain them so when extended for him. The flexors are not so much affected; they outbalance the extensors, and thus the fingers are permanently flexed. The extensor communis digitorum, the abductor pollicis, and the muscles of the forearm and hand are all atrophied. The legs and feet present similar lesions. The flexors

suffer here much more than in the upper extremities, the abductors being better preserved. The foot is drawn into the position of talipes varus, the patient walking on the outer border. There is no pyrexia; integument moist; pulse 72; respiration 24. The liver is normal in size, and offers no clue to any pathological change. The spleen is not enlarged, and were it not for this atrophy of the muscles, the patient would consider himself entirely well. I need not add that the face presents the same emaciated appearance as the rest of the body. The diagnosis of progressive muscular atrophy being arrived at, the following treatment was instituted:—At 8 A.M., milk; at 10 A.M., broth; at 1 P.M., egg-soup and boiled meat; at 4 P.M., coffee; at 7 P.M., egg-soup and meat. A placebo of tr. gentiani is administered four times a day.

That the prognosis is unfavorable will not surprise anybody; but that the disease should be inevitably mortal, is a conclusion in which I, for one, do not readily acquiesce. The only symptom of any gravity in the history of this case, is the haematemesis. This, however, seems to have been merely a symptom of some other affection, such as trauma of the pharynx or oesophagus, accidental congestion of the gastric mucous membrane, or chronic ulcer of the stomach, therefore I will leave it entirely out of the question.

That muscular tissue, after having undergone fatty degeneration, should be replaced or restored, no one will imagine. Virchow, in his able work on cellular pathology, has fully demonstrated this. To that form of fatty degeneration in which the fibrillæ themselves are softened and destroyed, he applies the term *necrobiosis*. When muscles are attacked by this form of degeneration, there is no hope of their ever again being restored to their original volume and activity, as the ultimate fibres, the fusiform cells themselves, are involved. If this were to occur suddenly, if this myomalacia were an acute process, the physician would be justified in folding his arms and doing nothing.

If the old muscle cannot be reproduced, if new muscle cannot be developed, must we allow the disease to *extend* during a

period of fifteen years, to the whole muscular system? That the atrophy cannot be checked by milk and broth, egg-soup and a little *tr. gentiani*, is evident. What would be the result of passive exercise, electricity, beefsteaks, egg-noggs, and cod-liver oil, combined with exercise in the open air? Would a man in a state of perfect health retain his muscles in a healthy condition if kept indoors and in bed, with milk and broth for his diet? Is it reasonable to suppose that a treatment which produces atrophy in healthy muscle will check it in diseased? In these cases we have too long been accustomed to do nothing, probably on account of their rarity and chronicity. In fact, it is not long since we have understood them.

This disease was formerly described as a progressive muscular paralysis. Van Swieten was the first pathologist to correct this error. Chas. Bell and Abercrombie have reported cases. The former attributed it to nerve influence, so that when Cruveilher, in 1853, discovered that the nerves were really atrophied, he was convinced, and declared that the muscular atrophy was caused by defective innervation. Prof. Oppenheimer, of Heidelberg, shortly after, proved this theory to be utterly erroneous, the *nerve* atrophy being consequent upon the *muscular*. But Virchow gives the most lucid description. He makes a distinction between *necrobiosis*, in which the sarco-sous elements themselves are the seat of the disease, and *fatty degeneration proper*, in which the connective tissue is the part affected. And thus, we may at present consider ourselves acquainted with the pathology of this interesting process.

But I have already encroached too much upon your valuable space; I leave the further consideration of this subject, expecting before long to learn that some method of treatment has been devised and found adequate.

Yours, most respectfully,

SAM'L COLE, M.D.

19 *Grossemandelgasse, Heidelberg, Baden.*

Editorial.

Meeting of the Alumni of Rush Medical College.

The enthusiastic response to the suggestion of a reunion of the Alumni of Rush Medical College, on the occasion of the opening of the new college building, has warranted those having the matter in charge to announce formally the time and place of meeting.

The Alumni will meet at the lower lecture-room of the new college, corner of Dearborn and Indiana Streets, Wednesday, October 2d, ensuing, at 10½ o'clock A.M. A society of the Alumni will then be formed.

The Twenty-Fifth Annual Session of the College will be introduced at 7½ P.M., by an address from Moses Gunn, A.M., M.D., Professor of Surgery, and the exercises closed by ceremonies of a social and festive character.

The JOURNAL does not hesitate to say that the Alumni of the College, practitioners and students, will be welcomed to the most magnificent lecture-rooms on the continent, by warm hearts and cordial greetings. Old friendships will be revived and strengthened, and new ones formed. It is intended that the new college shall be a Mecca, to which, year by year, the Alumni of "Old Rush" shall gladly come up to assist in welding new links in the professional chain, infinitely stronger than the cold-blooded Trades-Unions, which some think the only bond of professional union. Come one—come all.

Women-Doctors.

The following note explains itself. At the same time, we acknowledge the receipt of a Boston circular, to a similar effect:

"To THE EDITOR,

"Dear Sir:—Will you kindly insert the following in your paper, and aid a worthy cause?

"The New York Medical College for Women will begin their Fifth Annual Term, of 20 weeks, at the College in 12th Street, two doors east of Fourth Avenue, the first Monday in November. Address the Dean, Mrs. C. S. Lozier, M.D., 361 West

34th Street, N.Y., or the Secretary, Mrs. C. F. Wells, care of Fowler & Wells, N.Y."

It is in vain to protest against this thing, absurd as it clearly is. In this age, the greater the absurdity, the more strenuous its defence. The JOURNAL waives discussion.

To Subscribers.

Bills have been sent, as per published rates, to all subscribers who have not paid in advance for the JOURNAL. Mistakes will be cheerfully rectified, when pointed out, and full faith always given to the statements of our patrons. The books have been placed in the hands of a thoroughly competent bookkeeper, and order is rising from the chaos in which the present editor found affairs on remounting the tripod. Upon the conclusion of the *Endoscope*, space will be found in each number for a careful digest of current medical news, abstracts, items, etc. Lack of space has temporarily prevented the insertion of this chapter, which, hereafter, we hope to make one of large interest to our readers.

Cincinnati Changes.

Prof. E. S. Conner has resigned his position in the Cincinnati Medical School, to accept the Chair of Medical Chemistry and Physics in the Ohio Medical College.

Dr. D. S. Young has been appointed Professor of Surgery in the Cincinnati Medical College. Our correspondent in Cincinnati speaks of both these gentlemen in complimentary terms.

George K. Amerman, M.D.

At a meeting of the Chicago Medical Society, held at the Court House, June 28, Dr. J. P. Ross announced to the Society that a brother member, Dr. GEORGE K. AMERMAN, had departed this life, at Marcellus, N. Y., June 20, 1867. For nearly two years his health had been failing, and in April he had abandoned the practice of his profession, going home to die of consumption. Dr. Ross moved the appointment of a committee to prepare a series of resolutions appropriate to this sorrowful occasion. The motion having prevailed, the following gentlemen were appointed by the Chairman: Drs. Ross,

Holmes, Bevan, Heydock, and Marguerat. They reported as follows:

Having been informed of the death of their associate, George K. Amerman, M.D., the members of the Chicago Medical Society desire to testify for the deceased their respect, and their feelings of personal loss by these resolutions:

First. That in this affliction we lament the death of one who, long identified with our community, though young in years, was old in professional renown. A man whose life was a career of brilliant success, a Christian in deed, as well as in name, at the height of his reputation, he has now received the crown of immortality.

Second. That to the members of our profession we earnestly commend the example afforded by the life of our departed associate.

Third. That to the surviving relatives of our beloved friend we tender this expression of our sympathy in view of their bereavement, ever desiring with them to bow in humble acknowledgment of the almighty power of that God in whose hand are the issues of life and of death.

Fourth. That a copy of these resolutions be furnished to the relatives of the deceased, and to the medical journals and daily newspapers of the city.

The report of the Committee was accepted.

Dr. Ross then read a technical history of the last illness of the departed brother.

Dr. J. R. Gore, who had known Dr. AMERMAN from infancy, being invited to address the Society, proceeded to relate the following interesting facts concerning his friend:

At the time of his death Dr. Amerman was in his thirty-fifth year. The son of a rural farmer in Central New York, his boyhood was distinguished by fondness for study, and by disinclination to the drudgery of farm work. He was obedient and kind, but *good for nothing* on the farm. He early manifested a passion for teaching, and at the age of sixteen his only ambition was to become a school-teacher. His father, however, proposed that he should study medicine. To this he consented. Placed under the guidance of Dr. Gore, then a practicing physician in Owasco, N. Y., he pledged himself to pursue the study of medicine, subject to the direction of his preceptor, for five years before attempting to commence its practice. He accordingly attended three courses of lectures in the University Medical College of New York, graduating with honor in the spring of 1854. Still acting under the guidance of his preceptor, he secured a position for one year on the resident medical staff of Bellevue Hospital. The next year he became a member of the resident surgical staff of the same hospital. There, in the enjoyment of the friendship and confidence of the most distinguished physicians and surgeons of New York City, Dr. Amerman completed the fifth year of his course of study. At once received into partnership by his former preceptor, and removing to Chicago, he commenced the practice of his profession in 1856. He was appointed Surgeon to the Illinois Central Railroad, an office which he filled with great credit until the time of his death. He was also one of the Surgeons to the City Hospital, until that institution was closed during the war, and was the leading spirit in the surgical staff of the County Hospital from the time of its renovation until failing health compelled him to surrender his large and lucrative practice.

After listening to the remarks of different gentlemen who united in eulogizing the memory of the deceased, the resolutions were adopted, and the Society adjourned.

J. P. ROSS, M.D., President.

HENRY M. LYMAN, M.D., Secretary.

ACTION OF THE HOSPITAL BOARD.

At a meeting of the Medical Board of the County Hospital, Chicago, to take action on the death of Dr. GEORGE K. AMERMAN, the following resolutions were adopted:

Resolved, That the members of this Board have heard, with feelings of the deepest sorrow, the death of their colleague, Dr. Amerman, and desire to put on record their high appreciation of him as a gentleman and a surgeon.

Resolved, That in his death the staff of this Hospital has lost a most efficient member, and one most intimately identified with its best interests; that the profession at large has lost one of its brightest ornaments, and our community a most valuable citizen.

Resolved, That we believe his death was the result of too arduous devotion to his chosen calling, and that he has added another to that long list of glorious martyrs who have given up their lives in the cause of suffering humanity.

Resolved, That a copy of these resolutions be sent to his friends at the East, and to the public journals.

R. C. HAMILL, M.D.,
J. P. ROSS, M.D.,
H. W. JONES, M.D.,
THOS. BEVAN, M.D.,
J. R. GORE, M.D.,

H. A. JOHNSON, M.D.,
R. G. BOGUE, M.D.,
CHARLES G. SMITH, M.D.,
H. M. LYMAN, M.D.,
J. S. HILDRETH, M.D.

Erratum.

Our attention has been called to a typographical error in the June No. of the JOURNAL. The article on "Ovariotomy" was contributed by S. D. Jacobson, M.D., and not Jackson, as the types made it.

Crowded Out.

The article by Dr. Hutchins, our Philadelphia correspondent, is unfortunately crowded out of the present number. Will appear next month.

Books and Pamphlets Received.

The Physiology and Pathology of the Mind. By HENRY MAUDSLEY, M.D., Lond., etc., etc. New York: D. Appleton & Co., 443 & 445 Brodway. 1867. pp. 442.

A beautifully printed book, on tinted paper, in the publishers' best style. A work of profound thought and erudition, which we cordially commend to the careful perusal of all thinking and reading physicians.

A Treatise on Human Physiology; Designed for the use of Students and Practitioners of Medicine. By JOHN C. DALTON, M.D., etc., etc. Fourth Edition, revised and enlarged.

With two hundred and seventy-four Illustrations. Philadelphia: Henry C. Lea. 1867. pp. 695.

The present edition of this now standard work fully sustains the high reputation of its accomplished author. It is not merely a reprint, but has been faithfully revised and enriched by such additions as the progress of physiology has rendered desirable. Taken as a whole, it is unquestionably the most reliable and useful treatise on the subject that has been issued from the American press.

Dr. McDowell's Letter to the Assembly of Teachers at Cincinnati, Ohio, 1867. St. Louis: P. M. Pinckard & Co., Nos. 508 & 510 Pine St. 1867.

Pepper, salt, and mustard on excoriated backs. A pamphlet which proves that its eccentric author, although "chock-full" of quips, cranks, and prejudices, and particularly liable to "go off half-cocked," at all events has not a particle of humbug in his composition, nor will he put up with it in any wise. His own idea, that the action of the "Assembly of Teachers" was in the nature of a sectional attack on the South-West, is simply absurd. The majority of Northern and Western teachers entertain no such foolish prejudices as he attributes to them.

Personally, we look upon the proceedings of that "Assembly" as but a shallow device to galvanize sundry moribund schools into a semblance of vitality; to make more places for little men, anxious for position; and, particularly, to keep up the somewhat stale notoriety of sundry seedy parties who "live and move and have their being" (what there is of it) only whilst wriggling down to the footlights of some professional Trades-Union convocation.

Dear Bro. McDowell, the game is scarcely worth the candle.

ANGULAR CURVATURE OF THE SPINE. By Benjamin Lee, M. D., &c. An excellent brochure which we fervently recommend, as from the perusal of it, we have gained an unaccustomed comfort amid the dreamy platitudes with which we have been afflicted in times gone by. It is not an advertising dodge of some worthless though finical instrument, but a good sound little treatise.

CLINICAL INSTRUCTION AT THE CHICAGO CHARITABLE EYE AND EAR INFIRMARY.—During the winter courses of instruction at the medical colleges of Chicago, there will be regular clinical lectures on diseases of the eye at the Infirmary. This institution offers the medical student and practicing physician unusual opportunities for the practical study of diseases of the eye and of their medical and surgical treatment.

During the past year, *five hundred and fifty-five* patients were treated at the Infirmary, of which *eighty-seven* required important surgical operations. An aggregate of *3197* patients have received the benefits of the institution since its organization, nearly ten years since.

There has been an average daily attendance of 26 patients at the infirmary during the past three months.

Dr. HOLMES will give special courses on the use of the ophthalmoscope.

The Legislature of the State of Illinois, at its last regular session, appropriated the sum of \$10,000, for the support of the poor of the State, during treatment, at the Infirmary for diseases of the eye or ear.

The Legislature of the State of Wisconsin recently appropriated the sum of \$500, for the support of Wisconsin soldiers receiving treatment at the Infirmary for diseases of the eye, contracted in the army during the late war.

Trustees—W. L. Newberry, President; P. Carpenter, Vice-President; S. Stone, Secretary; E. B. McCagg, Treasurer; W. H. Brown, William Barry, T. B. Bryan, C. G. Hammond, E. C. Larned, Wesley Munger, E. W. Blatchford, Daniel Goodwin, Jr.

Consulting Surgeons—Prof. J. W. Freer, M.D., Prof. H. A. Johnson, M.D.

Attending Surgeons—E. L. Holmes, M.D., Prof. E. Powell, M.D.

Superintendent—G. Davenport.

Matron—Mrs. Davenport.

(Continued from page 400.)

into the perineum hard nodosities, readily felt by the fingers. A No. 5 bougie could be readily passed, with a slight discharge of blood; it was kept *in situ* for about two hours, then, on being withdrawn, the patient urinated somewhat more readily.

5th Jan. A No. 7 bougie is readily introduced, but remains pinched by the coarctation; it was left about two hours. The urinary function is more easy.

6th Jan. The patient is fatigued; he has had no stools since his entrance into the hospital; a bottle of Seidlitz water was ordered. The result was, not large evacuations, slight chills, and pain in the loins. He remains in bed, and takes only a light soup.

7th Jan. Leave him quiet, and give an enema, as follows: Rx. Valerian, gram. 2 (grs. 80), quin. sulph. 1 gram. (grs. 40), laudanum, Rousseau's, 10 gtt., camphor, 2 gram. (80 grs.)

8th Jan. This morning, the patient seeming well, the endoscope was introduced, it showed a retraction of the canal of the normal color; the stylet was passed, the mucous membrane in front of the coarctation was perfectly healthy. He passed the day well. At 3½ P.M., he took an enema of quinine, after having first taken a simple one which brought away much faecal matter; immediately he was seized with dizziness, palpitation, nausea, cold sweats, vertigo, and ringing in the ears. A few glasses of Seidlitz water and coffee without milk, and the sickness was allayed.

9th. This morning the patient does well; rest is given him. He is purged with a bottle of Seidlitz water, and takes an enema of 10 grs. (50 centigrammes) of the sulphate of quinine. In the evening he experienced the same symptoms as on the previous day, but less decided.

11th and 12th. The injections are repeated, and no return of the sickness; the febrile symptoms have not reappeared. A No. 4 bougie was introduced and left in for two hours. He experienced a pricking sensation in the canal, and some drops of blood came out with the first drops of urine after the withdrawal of the bougie. The flow is somewhat larger.

13th. This day was well passed; the enema was countermanded.

14th. The endoscope was again employed this morning. About 3 P.M., he had an intense chill, faintness, thirst, nausea, and pain in the kidneys; micturition was very painful, and for some hours left a condition of sickness.

15th. He was better. A bougie, No. 21, was introduced as far as the stricture and left for fifteen minutes, for the purpose of decreasing the sensibility of the canal and of dilating the coarctated spongy portion. The evening found him slightly fatigued, the bougie was reintroduced, and the injection discontinued.

16th. Same condition. Seidlitz water.

30th. Every day a large bougie has been introduced as far as the stricture; the general health is good. The endoscope is now applied, and a superior incision made the length and thickness of the coarctation. The discharge of blood is but slight. Immediately after, a No 20 bougie is introduced and fixed; the urine flows, the inconvenience to the patient is slight. In the evening he complains of sharp pains in the part operated upon, radiating towards the anus, but without either chills or fever. An enema of quinine is prescribed. The urine is freely passed, and there is a sero-purulent and somewhat sanguinolent discharge between the sound and meatus.

Feb. 1st. Condition satisfactory; sound withdrawn; bowels costive; tongue white; loss of appetite. Seidlitz water.

2d. Discharge diminished; still some pain in urinating, the flow being neither strong nor rapid, but better than before the operation. There is some suffering in the perineum and in the lower belly. Cataplasms.

5th. A No. 22 bougie introduced and left in place for ten minutes.

6th. Bougie No. 23. In the evening, chills and discomfort.

7th. Pass a smaller bougie and withdraw it immediately. During the day, he experiences slight chills, indisposition, a natural condition, and considerable pain in the parts cut. Injection of quinine.

11th. Each day, a metallic bougie is introduced and at once withdrawn; the urine passes well, but he is fatigued; his eyes are encircled, and almost every day he experiences slight chills,

20th. Sounds of Béniqué, Nos. 30 to 37, successively introduced without difficulty or pain. The condition of the patient, and by his own acknowledgment, is much improved.

22d. Bougies 35 to 41 sufficiently large. The patient complains of nothing, is up, eats heartily, urinates easily and without pain, and may be considered as cured.

Among the accidents which may be the consequence either of stricture or of traumatic lesion of the urethra, but few are more serious or more distressing than urinary fistula. To give their entire history would lead us from our legitimate subject; thus we must be content to confine ourselves to the results of endoscopic aid in their cure.

The usual treatment of urethral fistula consists in the employment of permanent sounds or repeated catheterism, after dilatation. By these means, it is proposed to prevent the flow of urine through the fistula, which most frequently cicatrizes when this secretion does not tend, by its passage, to keep up the abnormal opening. Often it is unnecessary to keep the sound in permanent place, as the fistula may cicatrize as soon as the urethra offers no further obstacle to the flow of urine. Unfortunately, it is not always thus, some of these fistulas remain, though the canal may be perfectly free. This persistence may be owing to the presence of gravel in the fistulous tract, or else to more or less separation of adjacent and subjacent tissues. In such cases, extract the gravel, and cause the adhesion of the separated parts. These are the evident indications to be fulfilled. I have succeeded in curing multiple fistulas by the buttonhole treatment of Syme, being careful to incise each sinus. But this is a grave operation, and, moreover, there are some cases kept up by neither gravel nor by decollement, but by the continuous passage of a few drops of urine. Cauterization of the urinal orifice will not avail, for the urine is introduced from above, and nothing can impede its effect upon cicatrization; or, if the lower orifice should close,

the effusion will soon reopen it. What, then, must we do to cause the closure of these fistulas? What, then, must we do to cause cicatrization. Modify the internal orifice. Cauterization of this orifice furnishes the most proper means to bring about this result, by freshening the parts, bringing about a healthy granulation, and also producing a temporary obliteration of the opening by the swelling of its borders and by the eschar which protects the farther parts of the urethra and permits them to rejoin.

Such are the ideas that induced me to apply, by means of the endoscope, the nitrate of silver to the urethral orifice of stubborn fistulas. The process for doing this is most simple:—

Having, by proper treatment, caused the disappearance of all obstacles to the flow of urine and the passage of the sound, by the aid of the endoscope, we examine the urethra from back forwards, until we find the opening of the fistula. This is sometimes difficult to do, because its edges may touch, or it may be located in the midst of an ulceration, but it may generally be discovered by means of a small violet red spot or one of the color of wine dregs. Often, a stylet or bougie can be introduced into the fistula and will show itself at the end of the endoscope, thus indicating its urethral opening.

In a case now in my service, traumatic in its origin, the orifice was recognized by means of a fungous vegetation, similar to those often found at the external opening of urinary fistulas. Two cauterizations destroyed this vegetation and laid bare the opening. The patient is still under treatment. In this operation, eschars, so far from being feared, must be hoped for, they are necessary. A small pencil of solid nitrate of silver, placed in an appropriate porte, should be used; in the absence of a proper instrument, melt the nitrate upon the end of the endoscopic stylet.

When the orifice of the fistula is discovered, nitrate of silver is to be applied, care being taken not to touch neighboring parts; it is to be left a short time, and efforts made to introduce it into the orifice. When it is thought that sufficient action has accrued, the caustic is to be withdrawn, and, to prevent excess-

sive action upon the neighboring parts, cotton impregnated with marine salt should be introduced, to transform the nitrate into an inoffensive chloride.

After the operation, there is but little pain, rather more, perhaps, than after the application of a solution of nitrate of silver, but still very bearable. The day following the cauterization, the passage of urine through the fistula is generally diminished and sometimes completely checked; yet, for all that, it must not be supposed that the patient is well, though such effects, to my great surprise, I have more than once experienced. The swelling which succeeds the action of the caustic soon subsides, the eschar falls, and the urine recommences to pass. Thus it is necessary to wait for some days so as to give the work of reparation time to set up the recommencement. The urine gradually ceases to pass through the fistulous opening, which ends by drying up (*se tarir*), and the cure is complete.

The following case will show the march of the cure:—

Slight Contraction of the Bulbous Portion—Laceration of the Canal behind the Stricture—Infiltration of Urine—Incision—Fistula—Cauterization of the Urethral Wound—Cure.

D., aged 35, employed upon the railway, married.

His general health good. Before his marriage he had a light blennorrhagia, which lasted fifteen days, and then disappeared, he says, without taking on the chronic form. During the past five or six months, however, he has experienced occasionally, and especially when heated, difficulty in urinating.

On the 6th of July, 1862, while transporting baggage to the ears, a heavy trunk fell upon his left ilio-pectional eminence. He felt considerable pain therefrom, but still continued his work. The next day, the pain continued, and he perceived a small tumor formed upon the course of the left spermatic cord; gradually the surrounding parts became swollen, and micturition difficult and painful. Still this did not impede his work for seven days yet. At length he decided to keep his bed, and called in medical aid. Hip-baths and leeches were ordered; then he came to the hospital.

On his entrance, he could not possibly urinate; he suffered much from this cause and from the tumor, now the size of a hen's egg, vertically elongated, in front of the left inguinal region, now hard and not fluctuating. Catheterism presents no great difficulty and gives issue to much urine, greatly to the relief of the patient.

The marrow, the scrotum, the penis, the left groin, the perineum are the seat of great œdematous swelling. The patient is most anxious; there is pain in the parts; and some febrile symptoms. Four incisions are made, two in the perineum, one in the left scrotum, and one in the groin; thence, came much pus and serosity; the pus without the smell of urine. Cataplasma.

The parts disgorge in proportion to the discharge from the incisions. A few days after, the pus takes on a urinous smell. A sound is left in the bladder. His general condition is excellent; no chills, no fever, and a good appetite.

In a fortnight, two of the incisions are cicatrized; the third requires two months to close; the fourth, situated at the left antero-superior part of the scrotum, remains fistulous, and, when the patient urinates, a portion of the liquid passes through it. He also perceives it in the cataplasma used on the wound. Bougies of Béniqué are passed, from No. 34 to No. 51.

9th Oct. Endoscopic examination, A violet red spot, easy to bleed, is found in the inferior half-circumference of the canal; this spot seems to surround the internal orifice. It is cauterized with a concentrated solution of nitrate of silver, applied by means of a cotton tampon passed through the sound of the endoscope. The permanent sound is withdrawn. The urine, the first time, passes with difficulty and in a scattering stream, but the ensuing day it becomes perfectly natural. The urinary discharge through the wound still continues.

16th. Second cauterization, by means of the solid stick of lunar caustic passed through the sound of the endoscope. During the day, there is a slight hemorrhage; the micturition is properly made about every hour. The discharge by the fistula diminishes in quantity.

23d—30th. The fistulous opening in the canal is again touched with the stick of silver. Metal bougies are passed almost every day. The improvement continues, and, on the 4th Nov., the patient is discharged, perfectly cured, the urethral fistula cicatrized, and the urine passes in a full and copious jet.

FIETH LECTURE.

The Prostate.—The Bladder.—Calculi.

GENTLEMEN:—We have now finished the study of the application of the endoscope to the diseases of the urethra; but you doubtless recollect that, in speaking to you of urethral granulations, I omitted those affecting the prostate, deferring their description to a later period. With these, we will commence our lesson to-day.

Ulcerations of the urethra, whether granular, herpetic, or arthritic, present the same characters in the prostatic as in other portions of the canal, only they more readily become fungous, and, consequently, it more often happens their character is masked, and thus it may be more difficult to distinguish them. In such cases, diagnosis must be based upon the progress and other symptoms. We must, however, remark that, most frequently, the endoscope will enable us to distinguish between these ulcerations.

Granular ulcerations in the bulbous and membranous region are, as we have seen, the most frequent cause of stricture, in consequence of the organic changes they cause, and which we have fully examined. In the herpetic region, owing to the different anatomical arrangement, retractions do not occur, as I have before said, but the congestion, the irritation kept up by the granulations, may end in a chronic engorgement of the gland. It might be said of the prostate as it has been of the uterus, that it is not the ulceration which brings about the engorgement, but the engorgement which supports the ulceration. It is certain, that in the prostate, as in the uterine neck, there are ulcerations kept up by organic chronic engorgement; but

study them well, and you will find that these ulcerations, which increase and decrease, disappear, even under the influence of treatment, and reappear without apparent cause upon the engorged organ, on ulcerations of an herpetic character, which can be as readily distinguished here as in the anterior parts of the urethra, though they possess less mobility. As to the true granular ulcerations, in the prostate as in the bulb, the uterine neck, or the conjunctiva, once cured, they do not reappear without the reapplication of the exciting cause.

There is no particular treatment for this affection, but if it should be necessary to employ special means, it should be to combat certain complications, such as inflammatory symptoms of the parenchyma of the gland, or of certain accidents caused by a swelling of this organ. For the rest, the endoscope gives us the means of attacking, efficaciously, ulceration which is no longer more difficult to cure than in any other region.

We have seen that the chronic inflammatory stricture heals spontaneously at the same time as the granulations which maintain it, but when it arrives at a certain point, whilst the swelling is more or less inflammatory, and the induration is established, it is obstinate in its course, and is the same as engorgement of the prostate.

I have often seen the prostate take on its volume and its functions reëstablish themselves in their normal state, in proportion as the granulations yield to treatment. Thus, in the prostate as in the rest of the canal, the granulations have the same character, the same progress, and yield to the same treatment; they act through a mechanism analogous to the mucous and the subjacent tissues. But here the analogies end, for the effects produced are not the same. So long as the contraction is almost exclusively due to the granulations, the engorgement of the prostate is well known to arise from other causes. They appear more frequently to arise from arthritic and herpetic diathesis, from scrofula than from hygienic influences whose actions are universally known. Of all the causes resulting from affections differing in their nature, but the symptomatic expression of which is somewhat identical, it is almost impossi-

ble to-day to arrive at a diagnosis with anything like certainty. We only hope that, with the era of endoscopic observations, we shall be able to elucidate the subject now so obscure to science. Already, the endoscope has permitted us to perceive the engorgements due to granulations. In the scrofulous engorgements with ulcerations, it gives also some positive characteristics.

In effect, when these ulcerations remain for some time, they go beyond the limits of the mucous, and then, in place of a superficial denudation, the endoscope reveals to us a true ulcer, deep and ragged, presenting, in a word, the appearance of a strumous ulcer.

We had, at the commencement of the year, in our ward, a patient afflicted with strumous ulceration and tubercles of the prostate, with urinary fistula of the same nature, upon which these characters grew more and more distinct in proportion as the lesion progressed. This man left us, thinking he could find elsewhere a cure, which he despaired of obtaining with us. In the case of this gentleman, you are well aware that the therapeutic treatment is very limited, but, however, it will be in our power, thanks to the endoscope, to convey to these deep-seated lesions the same topical treatment which we have known by experience to act favorably upon lesions of the same nature in exterior organs.

A consequence attending fixed ulcerations in the prostatic regions of the urethra, which oftentimes injures the patient, are seminal losses. It happens oftentimes that they constitute a constant symptom, or even become habitual, in fact, they return with sufficient frequency to merit special attention; but so much the more, without having exaggerated the importance which we have attributed to them, we can but arrive at the conclusion that they may become exceedingly grave. But, whilst they derive their existence from the ulcerations, they seem to disappear of themselves, or by simple means after the recovery.

This lesion may return under two forms, one, which can be attributed to the irritation of the orifices of the ejaculatory canals, accompanied by lively sensations, and often by profound

pains of the perineum; the other, which appears atonic, comes on with little sensation, sometimes in sleep, without the knowledge of the patient, and without awaking him; whilst he is awake, if the patient wishes to accomplish his virile functions, the least excitation will bring on the emission, and, as M. Troussseau has said in his lectures, it can but result in a sort of impotence, to which we ought to give the name of "spermatic incontinence."

In the one or in the other case, but oftentimes in the first, the semen which the patient loses is often mixed with blood, which proves the existence of the ulceration. This symptom may appear equally in all ulcerations, but above all in granular ulcerations; the losses which accompany tuberculous ulcerations appear more frequently from the atonic form; those which proceed from herpetic ulcerations are less obstinate than the others.

Apropos to this subject, another very similar symptom presents itself, which very much surprises and astonishes him who experiences it: the patient, in his sleep, experiences all the sensations of a nocturnal pollution, he awakes, and, with astonishment, perceives that no liquid has been emitted.

The idea which naturally presents itself, is that of a deviation of the ejaculatory canals which directs the sperm towards the bladder; but without taking into account the disorders which it is necessary to admit must arise from a displacement or deviation of the ejaculatory canals, the patients which I have had under my observation formerly, from normal ejaculations and elsewhere, the most minute microscopical researches do not show any trace of spermatozoa in the urine. There had been then, in the few cases that I have observed, a false sensation, a sensation without an emission.

This phenomenon is not, like the rest, a certain index of a prostatic affection, for I have seen healthy men, perfectly well, from this country in particular, who had experienced it; only in these cases it did not return or renew itself, as in the case of the patients.

A symptom oftentimes more rare, and which I have seen

alike upon patients affected with granular ulcerations of the prostate, is a sensation analogous to that which accompanies coition, a sensation which becomes, for the moment, painful, or, as a patient said to me, "a voluptuous pain," which endures without interruption during the entire coitus, and oftentimes for weeks, and horribly fatigues those who endure it. In the two patients who presented this symptom in the highest degree, it was accompanied by a pain sufficiently sharp that the patient located it at a certain point in the neck of the bladder. These two cases prove, beyond doubt, some nervous affections which have a great resemblance to hysteria. The one most gravely affected, of my two patients, had become a melancholy hypochondriac and had given serious uneasiness to his friends, and distinguished physicians had attributed the entire affection to a nervous disease.

In these patients, the prostatic region presented a granular ulceration; one of them, cured of granulations, was at the same time embarrassed with pains and all the other symptoms which attend an old catarrh of the bladder. The other patient, cured of his granular ulceration, preserved his fixed pain, which he said had its seat at the left of the opening of the urethra into the bladder, at a point where the canal is continued with the vesical cavity. He entreated me always to pay particular attention to this point, assuring me that I should find there the cause of his difficulty. In fact, when I commenced, after having emptied the bladder, to examine minutely the border of the orifice of the urethra, I discovered to the left a small, well-marked, red ulceration as large as the head of a large pin, which resembled a small fissure. I touched it with a small crayon of nitrate of silver, the pains disappeared almost immediately, obscured by the pain of the cauterization, and did not reappear; the patient became perfectly calm. The patient returned twice, at somewhat long intervals, for his pains had revived, and the same treatment allayed them. For many months, the patient appeared to me to be cured. I met him from time to time, he did not speak of his difficulty, but from his exterior or general appearance, I am inclined to think that

this melancholy hypochondriac is completely cured, as also the lesion which produced it. I do not know in what class of diseases to place the cases of these two men.

We have seen seminal losses caused by the ulceration of the prostatic region of the urethra, but it is not necessary to believe that they always arise from this cause, for they may originate from diseases of different nature and often remote or distinct from the genital organs.

In the enumeration which we have made of diseases of the prostatic portion of the urethra, we have not spoken of cancer, because it determines beyond doubt some symptoms which report themselves from the bladder, and which cannot be relieved or cured without attention to this organ. We will, therefore, return to this organ at once and speak of affections of the bladder, and, above all, of those which pertain to the neck of this organ. We will now occupy ourselves, gentlemen, with an endoscopic exploration of the bladder, and, as we did with the urethra, we will commence by the study of its healthy condition.

In order to examine the bladder with an open sound, like those which we used for the urethra, it will be necessary to clear it, for if the extremity of the sound becomes clogged with mucus it will be impossible to proceed into the cavity of the organ, in order to explore all the points. It is necessary then that the bladder be full at the moment of exploration, and, in consequence, we must employ a sound which will stop the flow of urine and, at the same time, allow the rays of light to pass in.

This sound presents the same form as the urethral, but it has not a lateral opening, and terminates by a little prolongment around the end, which separates itself at an obtuse angle; in a manner, it resembles, in its general form, the prostatic sound of M. Mercier, the introduction of which is so easy, as we have said, especially when there is a swelling of the prostate. At the angle of reunion of the two branches, the sound is pierced in the axis of the long branch by an oblique opening, closed by a little plate of glass with faucets, plain and parallel, carefully and solidly set in with mastic. It is this glass which retains

the liquid and allows the light to pass through; it should be oblique, because if it was perpendicular to the axis of the tube, it would be less clear before the vesical cavity than the interior of the instrument, it would make a mirror and reflect the illuminated points situated in front of it, and prevent from distinguishing points situated beyond it. Thus, also, at night, when we direct a strong light towards the outside of a window, we see in the glass, as in a mirror, the inside of the apartment, whilst the exterior appears entirely obscure.

The extremity of the small branch of the sound can be screwed on, so as to facilitate the cleaning of the interior face of the glass, this, however, is rarely necessary. We must be careful that the small addition be always well screwed on, so as not to let the liquid pass through it, for the smallest drop in the interior of the sound will interfere with the rays of light. You will easily understand, gentlemen, that if the bladder should contain a turbid liquid it will be impossible to distinguish anything of its interior structure, whilst it is diseased it is rarely that the urine is not made turbid by mucus, pus, or blood, and often by these three liquids mixed in various proportions, it will then be necessary to empty the bladder by the aid of an ordinary sound, which will serve also for the purpose of injections, so that it may be washed out.

When the water of the injections becomes very clear, then we may withdraw the ordinary sound and replace it with the "sonde à vern" which we have just described. Upon this sound we shall place the apparatus, which we have described in our first lesson, and shall then commence to examine. In an open or clear bladder, there is nothing to constrain the movements of the instrument, we can thus explore the smallest part of the internal surface of this organ, even to the border of the prostate, the vesical triangle, and the superior and inferior fundus. The anterior face escapes the examination; I have essayed to make this accessible, by means of a mirror placed at the extremity of the long portion of the sound, in front of the lateral opening, but the clearness not being sufficient, the field of vision is considerably curtailed, and, in fact, the result

amounts to nothing. I have not yet, however, renounced the hope of being successful, but, for the present, we must content ourselves with examining that portion which is accessible to us, then, by a happy coincidence, this portion is precisely the one which is most often diseased, and that which escapes our examination very seldom offers anything of interest.

We shall now learn, through the endoscope, the physiological condition of the bladder. The mucous membrane of the bladder presents a healthy and smooth surface, and a color analogous to that of the urethra, but ordinarily a little more pale, it is of a yellowish white, slightly rose tinted.

In certain subjects it presents, here and there, a number of superficial vessels, very minute, which are seen to appear at different points, and ramifying themselves, take very tortuous courses. Very often, these vessels are not seen in a bladder well filled, and one cannot perceive in the points which present themselves in the field of the instrument, that the surface is smooth and the color uniform. The only particularity that we have noted is, that we can reconnoitre, whilst it exists, the transverse angle or point which limits the "trigonus vesicale" from behind, and extends between the orifices of the two ureters. In regard to the size of these orifices, I have not cared to speak to you, because it is unnecessary.

In order to examine the urethral orifice, it is necessary to withdraw the sound as far as where the glass commences to reenter the urethra, then we commence to perceive the inferior part of the visual field, the border of the prostate, under the form of a small crossing from the superior concavity. This part is habitually more red than the vesical mucous membrane, and as the border which it forms intercepts the rays of light, the surface of the bladder oftentimes appears of a deeper color.

If we carry the extremity of the sound to the right or left, we can follow the contour of the urethral orifice; but, as in a moment, one loses the borders of this orifice, at the same time that it passes away, in place of appearing circular, its contour forms a crook, elongated transversely. But the state of health as we pass to the disease, commencing with the case which ap-

proaches least to a normal state, we shall find the borders of the organ anaemic and the congestion characteristic, the one by its pallor, the other by the redness of the membrane, in which the vessels become oftentimes more apparent. I have encountered the anaemic pallor in chlorotics or very feeble patients, and oftentimes in some cases of neuralgia of the bladder in chlorotic or debilitated subjects, the dilatation of the capillary vessels, with or without redness of the mucous membrane; sometimes, likewise, they detach themselves upon the healthy membrane, and oftentimes it is the only lesion which the endoscope shows in patients affected with hematuria, without calculi or organic affections. In this case, we often diagnose varices of the neck. They perhaps exist sometimes, but more frequent from my observations, already sufficiently numerous if one can suppose that the blood be furnished by the varices. There are some capillary varices which extend themselves over the entire membrane, or at least a great part of it.

Without these vascular dilatations in the case of hematuria, we encounter, sometimes, some ecchymoses of the membrane, sometimes considerably large and irregular, sometimes small and lenticular. I have observed, in two cases of scorbutic hematuria, that the color somewhat resembled a violet tint. I shall reapproach these light affections, grave without doubt, but more so in appearance than reality, the diagnosis of which would be difficult without the aid of the sight.

We shall meet with subjects which are taken, it may be in full health, or it may be in the course of some light affection or habit of the urinary functions, with violent pains of the neck of the bladder, with vesical tenesmus, hematuria, retention of urine, more or less complete; these symptoms, after a variable duration, subside rapidly, sometimes suddenly, but often they return at intervals more or less in length.

With like symptoms, and in spite of their complete subsidence, for sometimes there is no rest between the attacks, it is difficult not to believe that probably a grave and organic disease of the bladder exists, then whilst we cannot diagnose any tumor by catheterism. I have often known given, and I myself

have held, in similar cases, an unlucky diagnosis. It is difficult to avoid it with the ordinary means of diagnosis; but apply the endoscope, examine the bladder with care, and you will find an exaggerated development of the capillary vessels of the mucous membrane.

Whilst I have had occasion to observe some cases of this kind, it was upon patients subject to attacks of gout and rheumatism, and some vesical affections so closely resemble arthritic affections that I have been almost obliged to attribute them to the same cause, and as I regard this abnormal dilatation of the capillary vessels as one of the effects of arthritis, for the same reason that the capillary varices of the inferior members and of some other parts of the tegumentary system.

After the congestion of the mucous membrane, we arrive naturally at its inflammation. Acute cystitis cannot exist without danger or without pain, it cannot result in any advantage to the sick to practice an exploration by the aid of the endoscope, but if it be only chronic cystitis or sub-acute, and of that which accompanies the presence of calculi in the bladder, then it is practicable to examine without danger, and with utility, and to make an exact diagnosis of the lesion. In the first degree, we find a general redness with development of the vessels, which are oftentimes more numerous but less dilated than in the affections of which we have spoken.

In a degree more advanced, the redness of the mucus is more intense, and we cease to distinguish the vessels which are confounded in the general well-grounded tint. So that, in certain chronic cystitis, for a long time there is a general ramollissement of the mucous membrane which has lost its epithelium, and the surface of which has become uneven, rugged; in the autopsy we find it black, in consequence of the alteration which, after sudden death takes place in the gorged bloodvessels. In this case, it is often difficult to separate the bladder from the pus that it contains, and of which the thickest part rests adherent to the ulcerated surfaces, but if you proceed to fill the organ with limpid water, you will find the membrane of a deep red in places, and presenting the same rugged aspect that we see in